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# Monitored Coaching Interventions to Remediate Unprofessional Physician Behavior:

Case Discussions to Elucidate How it Works; Client Selection; Coach Selection; &  
How to Launch a New Program

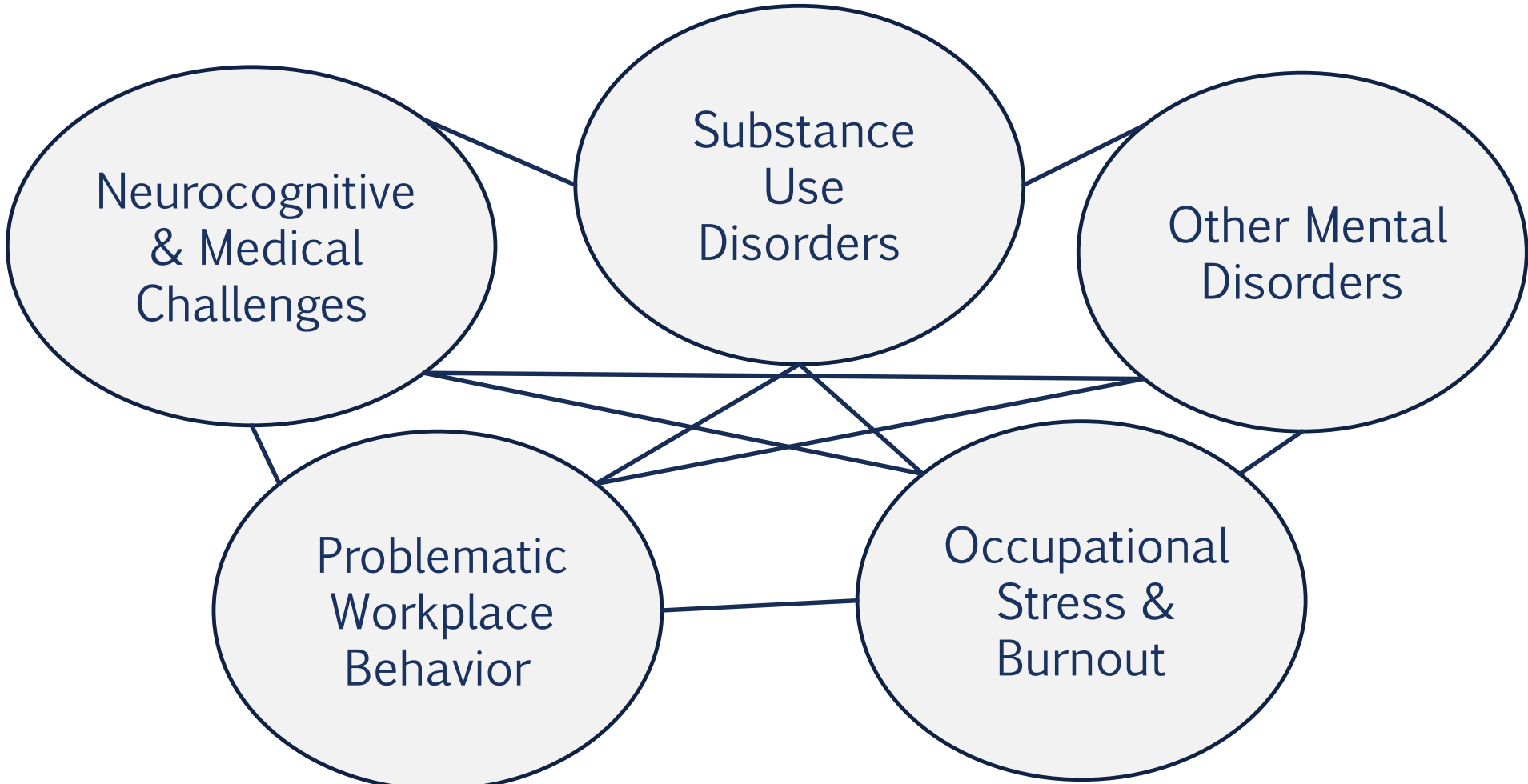
ICPH 2018, Toronto

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Physician Health Services, Inc.  
PHP of the Commonwealth of Massachusetts

# Agenda

- Varied & Expanding Scope of PHPs
- Problematic Behavior: Experience & Journey
- Professional Coaching
- Our OHMA Story
- Illustrative Cases & Case Discussions
- General Discussion/Q&A

# PHS Scope



Referrals vs. Self-Referrals

# The Problem We are Addressing

Substance  
Use  
Monitoring

BEHAVIORAL  
HEALTH  
MONITORING

SYMPTOMS?

Plays By Own Rules

Awkward Interactions

Disrespectful to Others

Angry Outbursts

Pattern of Bullying Behavior

Doesn't Stay on Top of Things

Persistent Complaints From/About Others

# Development of OHMA

Obtained input and feedback from:

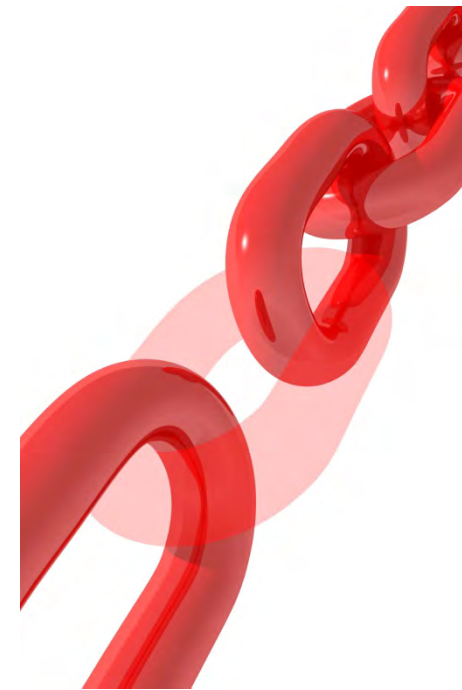
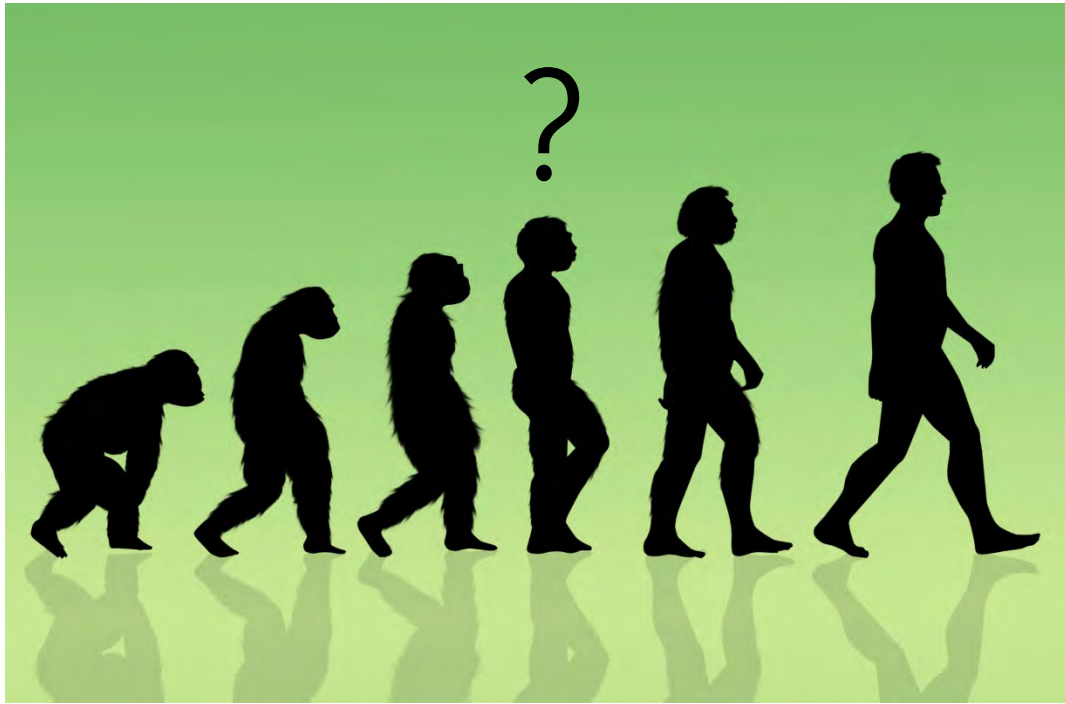
- Coaches
- Workplace Stakeholders
  - Hospital leadership (CMOs/CEOs)
  - Offices of the General Counsel
  - Departmental Chiefs
  - Practicing Physicians
- Licensing Board

Fit with our charitable mission to assist with health issues:

*“professional coaching for occupational problems (DSM 5, V code 62.29)”*

# Coaching: The Missing Link

Performance coaching for practicing health care professionals !



# The Coaching Industry's Belief: Coaching Works!

## ICF Online Coaching Survey (20 Minutes)

- No research design
- 2,165 coaching clients from 64 countries (11/08 - 9/09)
- Written coaching agreements: 64%
- Duration: Average = 12.8 months (73% less than one year)
- Frequency: Average = 2.5 coaching sessions per month
- In-person vs. phone = 50:50
- Session length: Average = 71 minutes in-person; 48 minutes by phone
- Cost: Average hourly rate of \$171; Total = \$4,353 per engagement
- Satisfaction: 96% indicate that they would repeat the coaching experience
- ROI for clients: median = 3.44:1

# Coaching: Is it Evidence-based?

**Health & Wellness Coaching:** A systematic review in 7/13 (Global Advances in Health & Medicine - Vol. 2, No. 4, pp. 1-20) demonstrates an “emerging consensus” as to what it is, pointing the way to future research to “assess the effectiveness of the approach.”

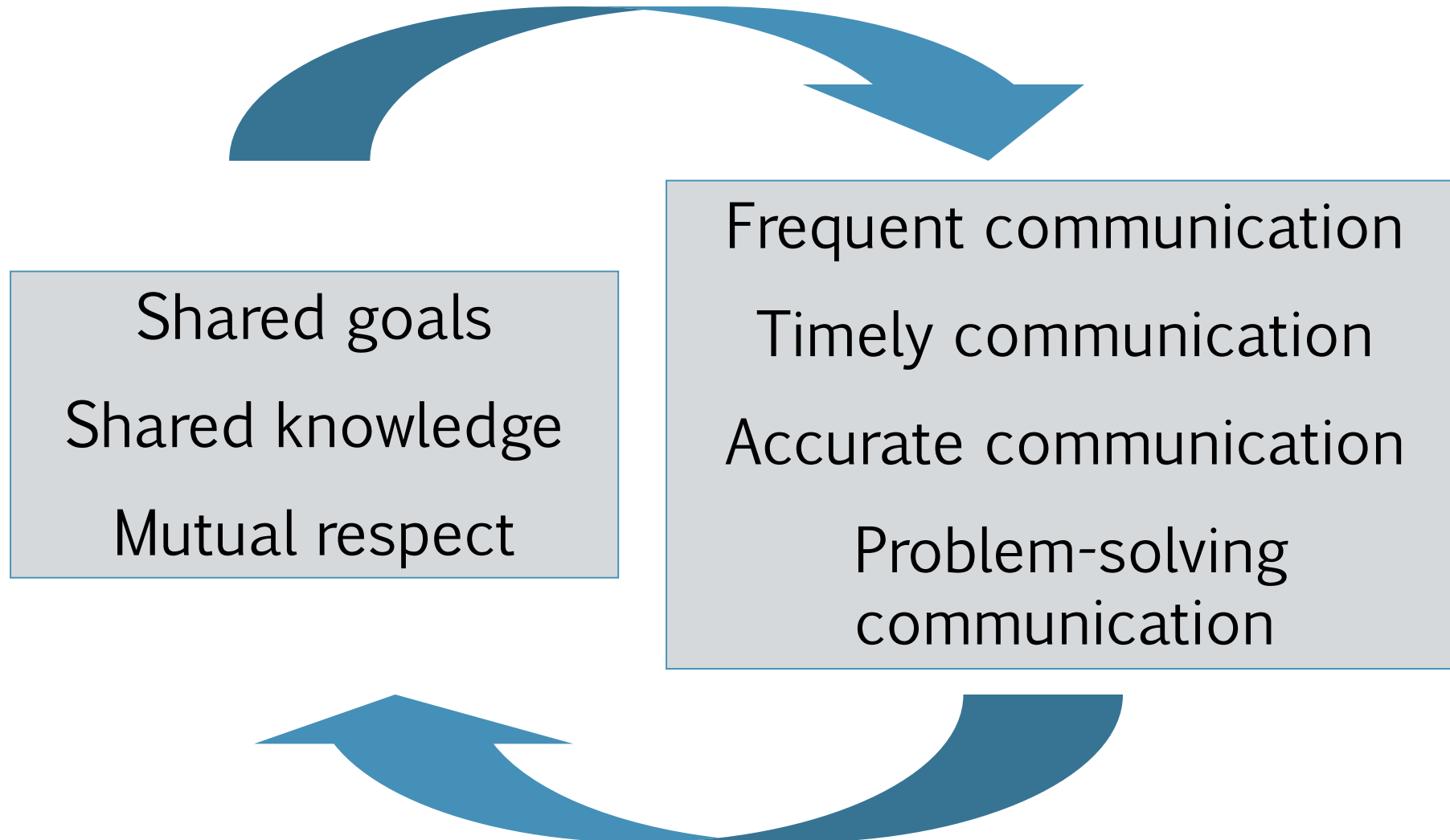
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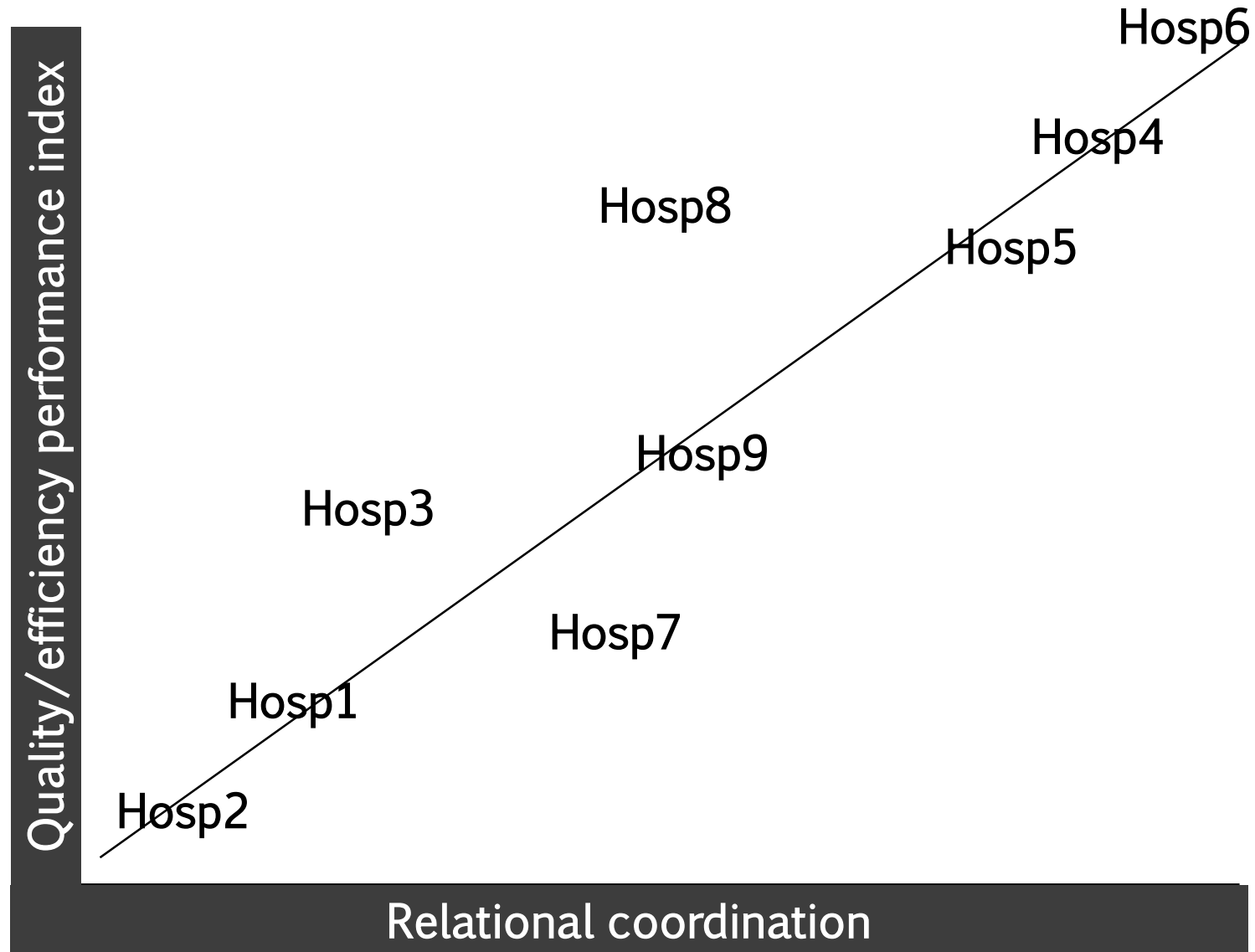


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# Relational Coordination



# RC and Total Knee Replacement



# Coaching: A Strategy For Addressing Workplace Challenges



- Set goals & solve problems
- Enhance professional skills: communications, workflow, interactions, etc.
- System interventions

# Coaches Help Clients Identify Goals & Take Action

## Improve:

- Self-awareness
- Social awareness
- Emotional intelligence
- Problem-Solving
- Communication
- Organization

## Diminish:

- Self-Defeating Thoughts
- Self-Defeating Behaviors (perfectionism; compulsive thoroughness; tardiness)
- Outbursts; Loss of Control; Passive-Aggressive Behaviors

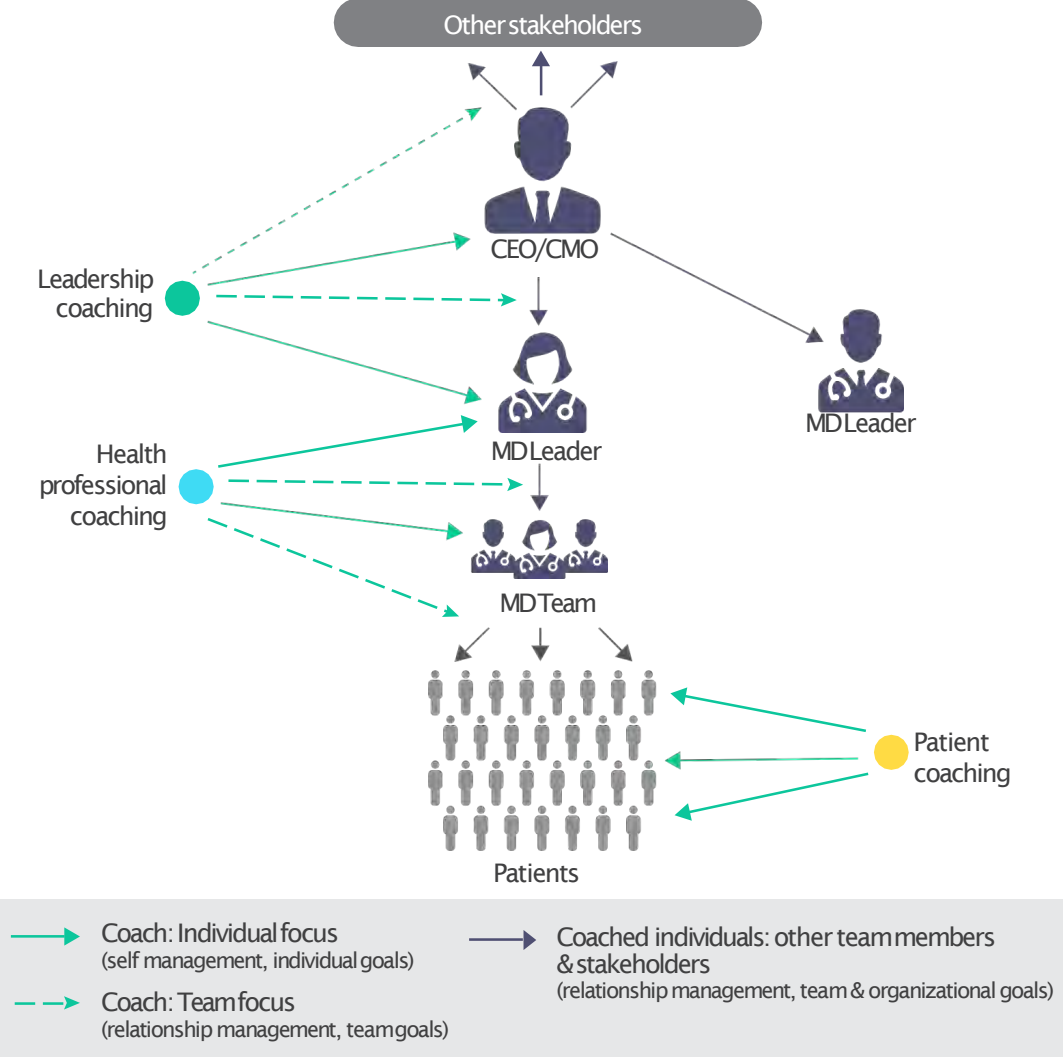
## Skill Development:

- Flexibility
- Resilience
- Saying “No” & “Getting to Yes”
- Mindful Practice
- Stress Management

## Align:

- Personal Values with Professional Duties
- Individual, Team & Organizational Goals

# Coaching Interventions Up & Down the Health Care Ecosystem



Source: Authors  
 NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society

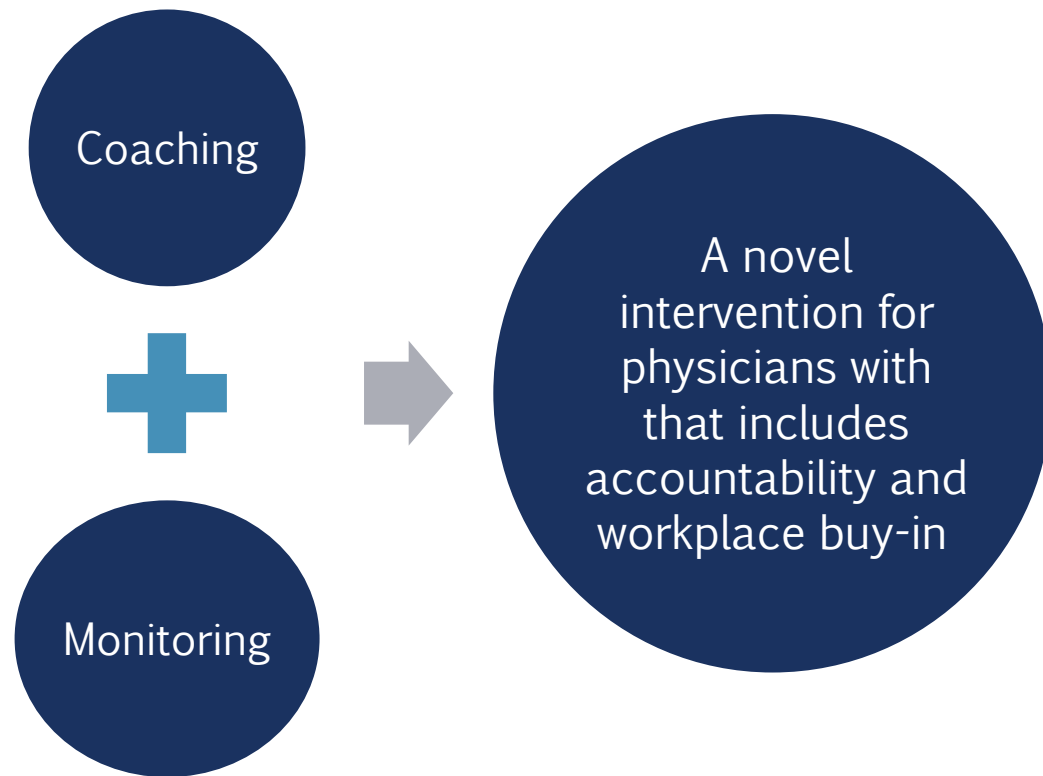


Google “NEJM Catalyst Coaching”

# Strategies

- Organizations develop their own programs
  - No published studies on effectiveness of these institutional programs
- Specialized courses to improve conflict management
- Referrals to professional coaches

# Occupation Health Monitoring Agreements



# Process

**Assessment:** PHS needs to rule out Substance Use and/or Behavioral Health issues

**Coaching vs. OHMA:** Independent vs. workplace-supported coaching intervention

Factors:

- Personal motivation
- Workplace investment



# Occupational Health Monitoring Agreement

- Noncompliance DOES NOT result in report to licensing board
- Monthly PHS Associate Director Meeting
- Professional Coaching
  - Approved Coach
  - Establish Identified Coaching Goals (Physician, Coach, Workplace, PHS)
  - Minimum Frequency (2x month – 2 hours total for 6 months, then no less than 1 hour a month for 6 months)
  - Written progress reports to PHS every other month

# Occupational Health Monitoring Agreement (cont'd)

- Workplace Monitor
  - Aware of Coaching Goals
  - Meets at least weekly
  - Provides regular feedback to MD, Coach, PHS
  - Written progress reports to PHS every other month
- Workplace Chief of Service
  - Aware of Coaching Goals
  - Provides regular feedback to MD, Coach, PHS
  - Written progress reports to PHS every other month
- MD Expectation: To maintain professionalism and actively work on identified goals

# Occupational Health Monitoring Agreement (cont'd)

- Flexible/Customizable
  - Peer support groups; Educational programs; Psychotherapy; Psychopharmacology
- 12 month (+/-) agreement with assessment of progress at 6 months and 10 months
- Does not replace the autonomy of the workplace to take action as needed
- Non-compliance = Termination of Agreement

# OHMA Goal Development

- Iterative 4-Party Process
- Sets Tone for the Intervention
- Coaching Goals vs. Coaching “Contract”
- Do the meetings with the coach to develop the goals count? (Who’s counting?)
- Sample Goals

# Sample Goals

1. Improve relationships with staff
  - a. Consistently speak & act more respectfully
  - b. Demonstrate more gratitude to staff
  - c. Be less critical of staff
  - d. Reach out to be more helpful
  - e. Check in to improve care coordination
2. Increase self awareness & self monitoring
  - a. Assess impact of my words & actions on others
  - b. Use mindfulness tools to improve communication & to express constructive thoughts & reactions
  - c. Complete formal mindfulness course

*Tools: Survey staff every 2 months*

- Survey practice manager & elicit input*
- Record concerns & positive feedback*

## Sample Goals (cont'd)

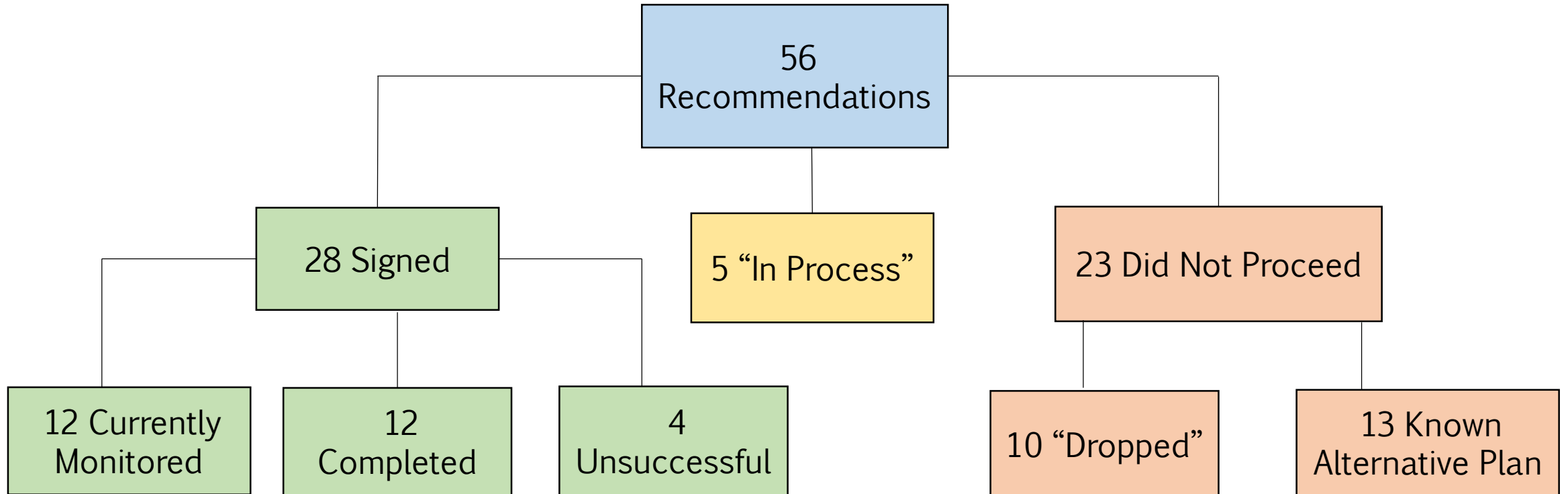
### 3. Improve relationships with patients

- a. Improve empathy
- b. Continue to give adequate time for concerns
- c. Continue to offer helpful interventions & support
- d. Continue to improve explanations of treatment options
- e. Monitor Press Ganey metrics for improvement

### 4. Practice Efficiency

- a. Improve time management while continuing to be available to help staff & patients
- b. Continue to enhance EHR skills & coordinate efforts with the MAs

# Four Years of Occupational Health Monitoring



# A Few Case Vignettes

Dr. Notmyproblem

Dr. Lastchance

Dr. Suture

Dr. Backandforth

Dr. Nastygram

Dr. Otherculture



# Failures?

Dr. Myway

Dr. Hadit

Dr. Onionskin

Dr. Moveon

# Dr. Plode

Dr. Plode is an “excellent” physician who provides “excellent” care to patients. However, he is known to have a short temper. He has a tendency to overbook, overschedule, and overcommit, and he can be particularly difficult when he has too much going on. That seems to be the case more and more of the time, these days. When he is at his worst, Dr. Plode makes derogatory and demeaning comments to nursing staff, humiliating the nurses in front of others, including patients. Those who have witnessed his outbursts experience him as intimidating and threatening, and they are afraid to report his actions in fear of retribution.

The CMO has addressed Dr. Plode’s professional challenges on several occasions. His behavior tends to improve for a month or two until it begins to deteriorate and return to its pre-intervention baseline. He has allies in hospital administration who think that he walks on water because he runs a high census, helping the bottom line.

*His department chair feels caught between a rock and a hard place. How might he proceed? OHMA?*

# Dr. Knowitall

Dr. Knowitall is a survivor. She is the daughter of 2 drug addicts and her childhood was divided between a series of foster homes and the streets. After obtaining an Associate's Degree in a Community College she joined the military and trained as a medic, seeing combat in the Middle East. After discharge she obtained a nursing degree, and after a few years working as an ER nurse she was admitted to medical school. The ER in her academic medical center has never seen an intern like her. She barks orders at nurses, attendings, patients, and families – her nickname is “Sergeant Knowitall”. She becomes dismissive and defensive when she is taken to account. Out of desperation, she is referred to the PHP.

*What obstacles do you image encountering in this situation? Is this a candidate for structured coaching?*

# Dr. Peter Out

After completing half of a surgical residency, Peter trained in Emergency Medicine because he was looking for a more manageable schedule. He was recently hired by the ED and has been known to complain to his colleagues that the hospital seems to be running the ER into the ground, with increased throughput and decreased staffing. His patient satisfaction scores are sub-par, and the ED staff barely tolerates his sullen, sour and subtly sarcastic ways. As a more senior physician charged with mentoring him, you have been meeting with Peter a couple of times a month for support and oversight. Although he can engage in reasonable conversations about clinical decision making, he is less than enthusiastic about the nature of the work itself. He cancels occasional meetings, and seems more and more remote and disengaged when you meet. At the end of a recent meeting you asked him if everything is okay and he quickly answered yes and got up to go. You followed-up by talking to some of the ED staff, and they tell you that more and more they feel as though they are walking on eggshells with him. They say that something seems to be eating him, and he seems increasingly hard to read.

*How do you go about helping physicians like Dr. Out in your setting? How do you think about PHP referrals, formal evaluation and coaching for a physician with this profile?*

# Dr. Asp

Dr. Asp is a mid-career proceduralist who has been the subject of multiple behavioral incidents over several years. Typically these involve refusal to prepare discharge paperwork consistent with hospital policy, impatience when OR schedules are disrupted due to emergencies, and, sometimes manifesting overly aggressive mannerisms and tone of voice when speaking to subordinates. At a recent PCC meeting this physician acknowledged that a few years ago that he was diagnosed with Asperger's syndrome. He believes that this condition predisposes him to react poorly to unplanned stresses and that his difficulty with following procedures such as med reconciliation at the time of discharge, etc. is a function of his overall poor adaptability to stress and uncertainty. He has stated that he does not feel comfortable reconciling internal medicine meds even when this is simply continuation of the patient's longstanding home med program after a brief surgical encounter.

*What do you think is going on with Dr. Asp? Where is this headed? How best to help him? Is this a candidate for monitoring? Behavioral Health or Occupational Health?*

# Topics For Discussion

- What are the pros and cons of coaching vs. psychotherapy?
- What are the pros and cons of monitored coaching vs. structured remediation off site?
- How does money fit into the picture?
- Are you considering monitored coaching in your program?
- If so, what obstacles do you anticipate in establishing a program?

# Let's Stay In Touch!

We'd love to help you establish a program! Call us at [\(781\) 434-7404](tel:7814347404).

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